MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 9, 2003
10:11 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Medicare+Choice in 2004
-- Scott Harrison, Tim Greene

DR. HARRISON: In this session we're going to focus on payment rates and plan availability in the M+C plan for next year. In its May announcement of the M+C rate increases for 2004, CMS announced that expected fee-for-service growth in Medicare for beneficiary will be 3.7 percent in 2004. The payment formulas feed off this number, and running that through the formulas we get the following updates.

Payment rates in floor counties will rise by approximately 5 percent. Rates in non-floor counties will increase by the legislatively set guaranteed minimum of 2 percent, plus 0.2 percent to account for increased coverage responsibilities from national coverage determinations, so the total increase there is 2.2 percent. Combining the effects of these rate changes, the average base payment rate for M+C plans will rise by 3.2 percent for next year. On top of these increases CMS is raising all county rates by 4.89 percent as part of the introduction of the new risk adjustment system in 2004. I'll get into this in just a couple minutes.

As you may remember, there are two absolute floors that vary with the characteristics of a county. One floor applies to counties in large urban areas, defined as metropolitan statistical areas containing more than 250,000 residents. The other floor applies to all other counties. The large urban floor was introduced in BIPA, and BIPA also set the floors at $525 per month for the large urban areas and $475 in the other areas. The rates are growing at the rate of per beneficiary fee-for-service spending growth, and the floor rates for 2004 are $592 per month in the large urban areas and $536 per month in the other areas.

Now note that as the floor rates increase at rates higher than the 2 percent minimum guaranteed increase more counties will have their rates raised by the floor. For 2004, about 7 percent of Medicare beneficiaries live in the counties that will be newly affected by the floors in 2004. In other words, they were not affected by the floors in 2003. These are some big counties; Montgomery County, Maryland and Denver, Colorado, for example.

Approximately 63 percent of Medicare beneficiaries and 40 percent of the M+C enrollees will live in floor counties in 2004. Back in 1998 when there was one national floor only 15 percent of beneficiaries lived in floor counties, and as recently as 2001 when the second floor was influenced 49 percent of Medicare beneficiaries lived in floor counties, and now we're up to 63 percent.

As a greater share of M+C payments are determined by the floor rates, payment policy moves farther from the Commission's stated objective of Medicare paying the plans equivalent to spending that would occur on those enrollees under the traditional program.

So how are M+C payments related to Medicare fee-for-service

spending now? While the increases in M+C rates have been below growth in spending in the fee-for-service Medicare program over the last several years, we estimate that for 2004 M+C plans will still be paid on average at rates higher than per capita spending in the traditional fee-for-service program. For 2004 we estimate that across all counties Medicare is paying Medicare+Choice plans an average of 103 percent of what it would cost to cover the current mix of M+C enrollees under the traditional fee-for-service program.

Medicare pays 110 percent of fee-for-service for enrollees in floor counties in the large urban areas and 113 percent of fee-for-service in other floor areas. By contrast, in non-floor counties Medicare pays 100 percent of average fee-for-service spending which just happens to match Commission preferences.

All these estimates though assume that the average health risk of M+C and traditional enrollees are the same, other than differences accounted for by the demographic characteristics. However, CMS has found that M+C plans enroll a less costly population than would be accounted for by demographics and, therefore, on average Medicare is paying M+C plans more than 103 percent of Medicare spending under fee-for-service.

Let's get into the effects of the risk differences between the two parts of the program.

CMS has estimated that plans enroll beneficiaries that are, on average, 16.3 percent less costly than demographically similar beneficiaries in the traditional program. The new risk adjustment system was designed to correct for this risk difference. I really should say that this 16.3 percent figure is based on simulations of plan data that was submitted--the diagnoses that were submitted by plans specifically for these simulation purposes. If plans were not successful in collecting all the diagnostic data then the difference will not turn out to be that large, but we don't know yet.

In 2004, plans will be paid a blended rate based 30 percent on the new risk adjustment system and 70 percent on the old demographic system. However, CMS has decided to compensate plans so that total payments under the new system in 2004 will be the same as if all payments were made under the old demographic system. CMS has chosen to accomplish this version of budget neutrality by increasing all county rates in 2004 by 30 percent of the total 16.3 percent, or 4.89 percent for 2004.

MR. HACKBARTH: Scott, can we go back to the first bullet because I saw a couple puzzled looks on what that meant? Let met see if I understood you correctly. So what CMS did was, based on data submitted by plans, compared to riskiness, if you will, of the current enrollees--

DR. HARRISON: Expected cost.

MR. HACKBARTH: The expected cost of the current enrollees with the fee-for-service population. Using this risk adjustment system they said that there's 16.3 percent less risky, or lower expected cost than the fee-for-service. However, this may overstate the difference. To the extent that the plans do not have all of the information properly coded, the patients may be sicker, if you will, than what this information suggests so the

gap could narrow somewhat as coding improves. Is that correct?

MR. FEEZOR: Narrow or increase.

DR. HARRISON: I think it's unlikely to increase. It would probably narrow if we thought that the plans didn't have all the data in from their different providers. I guess it would be unlikely to think that they had more data, more diagnoses than--

MR. HACKBARTH: When they're not paid to code correctly they tend to undercode and there's less complete information, which leads the patients to look healthier.

DR. HARRISON: Correct.

MS. DePARLE: Although you said this was a specific sample that the plans submitted for this purpose, right?

DR. HARRISON: Yes.

MS. DePARLE: So we assume they had every incentive to code properly.

DR. HARRISON: It only gave them an example of what the impact would be. Payments are still based on a model completely calibrated by the fee-for-service data.

MR. HACKBARTH: I guess the other important point is that even if Scott is directionally correct; namely, that the difference would tend to narrow, it's hard to say how much it would narrow. It probably doesn't account with the full 16.3 percent.

DR. HARRISON: Probably not.

MR. SMITH: Glenn, if I could just stick with this for a minute to make sure I have my arithmetic right. Would it be right to say that the effect of the CMS decision to rates by 4.89 percent is the same thing as having put off the blended rate?

DR. HARRISON: Not doing anything for risk adjustment, right..

MR. SMITH: The math is the same.

DR. HARRISON: Right.

What they did was they didn't touch the 70 percent, and they did touch the 30 percent but then they gave it back. The point is that this treatment of risk adjustment would most likely push M+C rates further from the fee-for-service level at which the Commission had recommended the M+C rates be set.

Now I do want to note that these higher payments based on risk differences between the plan enrollees and fee-for-service beneficiaries is not a new problem, however, we didn't have a number to pin this to before. Also, the 4.89 percent portion has now been made explicit. That portion will grow if the adjustments continue to be made as risk adjustment is phased in fully. I should also note that CMS has not committed to paying the budget neutrality factor to plans after 2004, and if they do not then payments will get closer to fee-for-service levels.

MS. BURKE: Scott, can I ask a question? I just want to be sure that I understand what the impact of the neutrality provisions are. In making the adjustment, the 4.89 in order to--essentially to recover the amount that would be lost as a result of the blending, the impact will vary by plan. So that it's not absolute neutrality by plan, it's neutrality against the system.

DR. HARRISON: That's correct.

MS. BURKE: So you may still have, presumably, variances and

there may be plans in fact who do less well as a result of the transition.

DR. HARRISON: Yes.

MS. BURKE: In which case, what are the expectations that we're going to end up with a series of appeals to be more specific in the neutrality adjustment? You're going to have winners and losers.

DR. HARRISON: They vary by plan.

MS. BURKE: That's my point. So having had to set floors and do a variety of other things to protect people, one could only assume--

MR. HACKBARTH: So 4.89 percent is the right increment for the plan that has a selection of risk that matches traditional Medicare, normal selection of risk?

DR. REISCHAUER: No, it's average for all Medicare+Choice plans.

MS. BURKE: It's the average, so there will be big winners and losers potentially.

DR. HARRISON: Yes.

MS. BURKE: So one could only imagine that there may well be attempts to further correct for this temporary period, correct? If history repeats itself, one could imagine that we're going to be asked to go in and save somebody.

MR. HACKBARTH: If everybody is interpreting budget neutrality as budget neutrality for me.

MS. BURKE: Theirs; correct.

DR. REISCHAUER: These guys have been playing around with this for a couple of years now. They all know this was coming and we haven't heard, I don't think, any big screams about it.

Let me ask you if I'm right here. This 103 percent wouldn't change at all if we completely phased in risk adjustment and gave another 11 percent increase, right? It offsets.

DR. HARRISON: No.

DR. REISCHAUER: The 16 is--beyond the 4.89. Two more slugs of 4.89, but then we reduce the payment because we put in risk adjustment fully, so that would lower everything. Then that we lower it back up. If we do the calculation it would still come out to 103.

DR. HARRISON: That's my next point, if that were the case you'd end up paying about 120 percent on average because you'd be paying the 103 just for the base rate differences and on top of that you would have given back 16.3. We have 103 percent that we talked about before, and that's just the base rate differences. That assumed that everybody was--

MS. BURKE: That's the floor.

DR. HARRISON: That's right. Now on top of that--

DR. REISCHAUER: But then if you did not do budget neutral risk adjustment it would lower it down. You'd lower it down and with the extra money you bring it back up.

MR. SMITH: You'd end up at 103.

DR. HARRISON: -- but that's adding the 4.89, and twice more.

DR. REISCHAUER: What I'm saying is, we're at 103 and we're at 30 percent risk neutrality, we go from 30 to 100 percent risk

neutrality which lowers the payment so we're way down below 103. Then we add the money back up and we're at 103, not 120.

DR. HARRISON: We'd be at 103 but for different populations then, because the M+C population would be less costly. The 103 ignores any risk differences. Now if these risk differences really are there, then you would be paying 16 percent above the 103.

DR. ROWE: I'd like to point out that I believe the discussion has an implicit assumption in it, or at least the material does as you read it, when we make all these comparisons as to what the health plans are getting paid versus what CMS is paying in the traditional plan. It's 103, it's 105, it's 120, it's 130, et cetera. The implicit assumption is that the health plans' cost are the same as Medicare's cost and therefore this is profit or they're being overpaid or something. It might be worth having a sentence in the chapter that says, that the health plans are paying--

DR. REISCHAUER: So less efficient--

DR. ROWE: --are paying 130 percent of Medicare to the hospitals and 108 percent of Medicare to physicians nationwide, or something like that that at least give a little sense of fairness, because otherwise the whole conversation goes on without any reference to these higher costs.

MR. HACKBARTH: I think it ought to be explicit in saying that the private plans cost more than traditional Medicare.

DR. ROWE: I think that would be fair, because of contracts with the providers.

MR. HACKBARTH: They pay providers more.

DR. ROWE: We pay the rural hospitals more, we pay the physicians more.

MR. HACKBARTH: Even after you adjust for the difference in benefit package they cost more.

DR. ROWE: But there's nothing in the chapter that I saw about benefit package differences or contracts with providers. I think it's the other side of the coin.

MR. HACKBARTH: I agree with that. I think different people will interpret that differently and draw different significance from it. Plans, we're being underpaid; it's not covering our costs, and proponents of traditional Medicare will say--

DR. ROWE: That's not our problem.

MR. HACKBARTH: Right. They can't do it as efficiently.

DR. ROWE: I understand that. I just think it would provide a little balance.

MR. HACKBARTH: That is the bottom line.

DR. ROWE: Could I make another comment which you may or may not want to include? I might want to quit at the point that I got something in.

If you're going to talk about why people didn't pull out, which in the main they didn't. I think Wellpoint pulled out Atlanta and otherwise basically nobody pulled out.

DR. HARRISON: Right. That's coming.

DR. ROWE: That's basically what happened this year. Why did that happen? I think one of the answers is that health plans are waiting to see what's going to happen in Congress with the

Medicare bill, and if the new Medicare proposal, the administration's third pathway proposal doesn't get passed or that people think that people might go back and put some more money into Medicare+Choice because they want to continue to preserve the option. And that as a consolation prize or whatever there may be--but no one was interested in putting that extra money in now because they didn't want to distract people from this new proposal that they wanted to draw attention to and support.

So many of the health plans, looking at what was going on said, we really have to wait another year to see what's going to happen to the Medicare+Choice funding, so it would be premature to pull out, but we don't want to go into more counties either because we're not sure. So I think that's an explanation, one man in the street explanation for what may have been going on in people's minds as they were looking at this.

MR. HACKBARTH: Just the average man on the street.

DR. REISCHAUER: Is that Wall Street, Jack

[Laughter.].

MR. HACKBARTH: We need to press ahead, so Scott, lead the way.

DR. HARRISON: Jack got a little ahead of me, but how are plans responding and how will they be participating under these rates for 2004? As far as plan participation goes, I guess the interpretation is up to the individual. The M+C program has stabilized. Less than 1 percent of current Medicare+Choice enrollees will be affected by plan withdrawals this year. Of those enrollees who will lose their coordinated care plan, only about 1,000 live in areas not served by another Medicare+Choice coordinated care plan.

Also since the start of the year new plans have entered the program and expanded their service areas. Currently CMS lists four plans with pending applications into the program and another 15 non-demonstration plans seeking service area expansions. Beneficiary participation in the program has been flat over the last year and, unfortunately, we don't yet know how benefits and premiums will change for 2004 and, thus, we can't suggest how those changes may affect beneficiary enrollment for 2004.

Here's a chart on the availability. The chart includes the effects of pullouts for 2004, but we do not have any information on how new plans may affect availability. But at least 63 percent of Medicare beneficiaries will have a coordinated care plan available in 2004, up from 61 percent at the beginning of this year. Although a new private fee-for-service plan joined the M+C program this year, Sterling, which is the largest fee-for-service plan is reducing it's service area by withdrawing from over 500 counties. As a result, only 32 percent of beneficiaries will have access to a private fee-for-service plan compared with 34 percent earlier this year. However, CMS does list two plans as having new M+C private fee-for-service applications pending, so we could have some more next year.

So for 2004, 77 percent of beneficiaries will have an M+C choice available, down from 78 percent at the beginning of 2003. Beneficiaries living in floor counties are much less likely to

have a coordinated care plan available than those beneficiaries living in non-floor counties, although they are more likely to have access to a private fee-for-service plan available. Those differences have narrowed, although a good portion of the changes are really attributable to counties shifting from non-floor to floor state.

Despite the overall increase in coordinated care plan availability, rural areas continue to lag with only 16 percent of rural beneficiaries having a plan available. Also virtually all of the loss in the private fee-for-service availability occurred in rural areas.

Some of the other work that we plan to complete includes examining the benefit packages and premiums of the M+C plans and then examination of the enrollment in the PPO demonstration plans to see how those plans are affecting the overall M+C program. Of course, we will report on any legislation that comes along that would affect the program.

MR. FEEZOR: Scott, good work, and despite how hard we tend to make your job around here. I wondered, just reading this excerpt itself, I had a little problem drawing the conclusion looking at the same facts that you did that the plan has stabilized. It's sort of like saying that you've got plans that are making application--that's sort of like intentions. Execution is different. I guess I'd bit a little more cautious. I think we need to do two things. Either we need to be a little more cautious in our judgment, as perhaps rather than stabilized that it's in a period of uncertainty, particularly when you give the fact that there seems to be a rather flat enrollee choice. That, after all, is the most important measure, I would argue.

Otherwise we might want to, in some of our charts, show a longer period of history which does show that there has been a significant decline for a lot of understandable reasons that we've opined on and analyzed in the past. This does seem to be a leveling out. But to say that it has stabilized on the evidence that we've presented, I have little trouble with that language and I think we need to soften it a little bit. I would argue that probably just by what Jack said, there really is, because of some other potential policy changes, there's a lot of uncertainty around it, both from enrollee and from probably the insurer side.

DR. ROWE: I think, Allen, one point relevant to what you said is, one way to look at the lack of increase in enrollees is that there isn't any marketing out there. That if people are really going sideways and it's a wait and see, then this is not the time when you're going to be expending a lot of resources on marketing because you may be getting out of--you're waiting and seeing. So you wouldn't have marketing, and when you don't have marketing you don't have as much enrollment. So I think it's consistent with what I was saying.

MR. SMITH: Picking upon Allen's point and offering at least a competing explanation, Jack, is it's not the same product, and it's more expensive. So we're not comparing the same thing that people were selling in 1999 to what's being sold today, and talking about stabilization it's important to make that point as well.

DR. STOWERS: Scott, I had a question if you just had a concept of this. It may be silly. But if we were to take the areas where Medicare+Choice is not available and we added on the benefits that are additional in Medicare+Choice, primarily the drug benefit, what would the plus be? Would it be a plus three to add on those benefits in traditional Medicare or would it get up to a plus 20?

DR. HARRISON: You mean the actuarial of an M+C plan?

DR. STOWERS: Right, and adding it onto base fee-for-service. In other words, I think there's where you'd start seeing the efficiency of the delivery systems. Just curious. In other words, we've got this package that's out there in certain areas where Medicare+Choice is available and then we have the fee-for-service areas where it's not available so there's a difference in the benefit package essentially in Medicare+Choice and in traditional because there's no--how much would it take to add on to the traditional Medicare fee-for-service payments to get the rest of the population up to the same benefits?

DR. HARRISON: In other words, how much would you have to raise rates by in some of the rural areas to get plans to come in?

DR. STOWERS: Yes, rural or urban. Just areas where there's not the Medicare+Choice plan available. How much more would we have pay in fee-for-service to get that benefit out there?

DR. HARRISON: I think there was a study--

DR. NEWHOUSE: Yes, there's an old ProPAC study.

DR. HARRISON: There was a simulation done a couple years ago that suggested you're talking lots and lots of money.

DR. REISCHAUER: But I don't think that's relevant now because the Medicare+Choice drug offerings have shrunk very, very significantly and virtually all of them or a very high percentage are charging premiums now. What you want is the net benefit of the actuarial cost of the drug benefit minus the premiums that people are paying that's over and above. I don't think it would come out to be much money. But it wouldn't offer much protection either.

DR. NEWHOUSE: You'd have to also add in the value of copay reduction.

DR. ROWE: It wouldn't offer protection for a population but it might for individuals, right? It might be a net--

DR. REISCHAUER: An awful lot of these things now have limits that are relatively low, $1,000 or less, and they're broken down by quarters so you don't get more than $250 a quarter something like that, so you really aren't offering people with large drug expenditures the catastrophic protection that they would expect.

MS. BURKE: Scott, in terms of your plans going forward and the things that you anticipate doing what's not noted is looking at the implementation of and the impact of the payment change; essentially the phasing in of the risk adjuster and shoring up for a short period of time and how that differentially impacts. Is that something you would imagine doing? Again it's the question of neutrality will hit people differently. In some places it won't in fact be neutrality. So is that something that

you anticipate coming back and telling us how that works since they're only proposing to do it for a year, presumably it's something of a predictor in terms of who's going to be--

DR. HARRISON: I believe CMS has at least done the simulations. I don't know whether I've seen any results of what the distribution would be in terms of plans. We can ask and find out.

MS. BURKE: The reason I ask the question is at least historically when there were--literally when we were going county by county and determining what rates were going to look like it became the focus of a lot of activity, depending on where geographically they happened to be located. So it might be of interest to us to have anticipated where you're going to see big shifts, if you are. Maybe the impact won't be great but it will be instructive, I believe. One might want to look going forward at what that has looked like, because if they're only proposing to do neutrality for a year, I assume they've also done the rollout in terms of what those numbers, what the allocation and the impact is going to be in the outyears of fully phased in--

DR. NEWHOUSE: If they have a sample they probably don't have enough to do--

DR. HARRISON: I assume hey have the full impact analysis.

MS. BURKE: My guess is they do.

DR. HARRISON: But it's not clear whether they're going to do it past 2004. We're in this gray area. There's been differences of opinion about what the law says about whether they're supposed to be doing this, how the budget neutrality is supposed to work.

MS. BURKE: But I could lay odds, if Mark hasn't already heard, that we will begin to hear the patter of little feet around issues of the predictions of what those allocations are going to look like and what the impact is going to be geographically.

DR. REISCHAUER: The law says that they have to phase the risk adjustment in in two more steps, right?

DR. HARRISON: Yes.

DR. REISCHAUER: But the question of whether they make the positive 4.9 judgment is still up in the air. The patter of little feet probably won't be to the Hill, it will be to the executive branch which made this decision before.

MS. BURKE: Perhaps. But it could also be to the Hill.

DR. REISCHAUER: But also these plans have had a pretty good idea of how their payments weren't going to be affected I think for the last six months and my guess is when they submitted their rate increases for 2004 they built in what they had to charge to compensate, if they were hurt or if they were benefitted. If they didn't, they'll be out of business and they probably should be.

MS. BURKE: I don't doubt that, but I think just for instructive purposes it will be interesting to look at what those shifts are going to be like and the phase in.

DR. HARRISON: I will request that from CMS. I don't know whether they'll give us stuff we can break down geographically.

MS. BURKE: That's fine. Because we used to literally get

it by county. I could have told you exactly who was going to get what in what county for what plan.

DR. NEWHOUSE: This would also change sometime as enrollment changes.

MS. BURKE: Absolutely. It will change for a variety of reasons but it will be a base against which you can anticipated if Florida is differentially, or Iowa would strike me as being of interest.

MS. DePARLE: Just as a point of information, Scott, you referred to the dispute about budget neutrality in this which I remember quite well, but I thought Congress in the end in a law--I guess it would have had to have been BIPA--instructed CMS to not make it budget neutral. I thought--or to make it budget neutral. CMS when I was there our position was--

DR. HARRISON: I believe the language resides in a conference report somewhere.

MS. DePARLE: Okay. But when I was there our position was that it was not intended to be budget neutral. Then I thought after that there was some congressional mandate--intervention.

DR. HARRISON: Right, and the intervention was not in statute. I believe it was in the form of conference language or something.

MS. DePARLE: So that's why they're saying that they may not do it in the future, or they have not opined--

DR. HARRISON: I think they haven't decided whether it cost them budget money or not.

MS. DePARLE: It depends on what you use as the baseline, which I would think it probably does.

Are we going to make recommendations on this?

MR. HACKBARTH: We actually took this question up in the abstract, I guess it was: how do you do the budget neutrality? How do you phase in the new risk adjustment? The position that we took was that you should not make this sort of budget neutrality adjustment. What we're striving for is to have our payments to health plans be equal to traditional Medicare after risk adjustment. So you shouldn't be throwing in new money to offset the fact that they have lower payments due to healthier enrollees. I think that was two years ago that we took that position, and I personally think it was still the right policy.

DR. REISCHAUER: And you can see what an impact it had.